Wyoming Department of Health

Commit to your health.

WYOMING MEDICAID PROGRAM

Community Mental Health & Substance Abuse Services Manual
For
Mental Health/Substance Abuse Rehabilitative Option
EPSDT Child & Adolescent Mental Health Services
Targeted Case Management Option Services

Mental Health & Substance Abuse Services Division

9/22/2007

This manual supersedes all prior versions. Providers must be familiar with all current rules and regulations governing the EqualityCare (WY Medicaid) Program.
In the event that the manual conflicts with a rule, the rule prevails.
It is the provider's responsibility to verify this information.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 1: Provider Enrollment and Participation
Section 01: Participation Requirements

101 PROVIDER ENROLLMENT CRITERIA

The following criteria shall be met by a mental health and/or substance abuse center to be enrolled as a Medicaid provider.

1. Certification

Prior to enrollment as a Medicaid provider, a mental health center shall have received certification from the Mental Health Division and a substance abuse center shall have received certification from the Substance Abuse Division as evidence of compliance with Standards for the Operation of Community Mental Health and Substance Abuse Programs. The center shall also have resolved any compliance deficiencies within time lines specified by the certifying Division

To become a provider of Medicaid mental health services, an agency shall apply for certification as a mental health and/or substance abuse Medicaid provider by submitting the Medicaid provider certification application form and its required attachments to the Mental Health Division or Substance Abuse Division. The Applicable Division shall establish that the agency meets the criteria for provider certification and issue to the provider a Medicaid contract for mental health and/or substance abuse services, depending on type of program certification.

2. Audit

Agencies currently enrolled as Wyoming Medicaid providers shall submit financial audits to the Department of Audit and to the Mental Health Division and/or Substance Abuse Division within 180 days of the close of each State fiscal year.

The audit shall be performed by an independent certified public accountant and shall include:

a. A financial audit which meets the requirements of the State Department of Audit.

b. A statement of internal controls.

c. For new providers, results of testing a sample of insurance billings to determine that billings match clinical records entries describing services provided.

d. A contract compliance audit verifying compliance with the purchase of services contract between the provider and the Mental Health Division or between the provider and the Substance Abuse Division.

The audit submitted shall be judged acceptable by the Department of Audit. The Mental Health Division, Substance Abuse Division, or the Department of Audit may require the provider's board to address in writing a response to any audit deficiencies or recommendations.

3. Provider Contract

The provider shall sign a mental health and/or substance abuse services contract with the Mental Health and/or Substance Abuse Division.

4. Quality Assurance Plan

The provider shall have a written quality assurance plan that meets the criteria described in Chapter 3.

5. Enrollment as a Medicaid Provider

After the agency signs a Medicaid contract with the appropriate Division, the agency may enroll as a provider with Wyoming Medicaid. The agency will be required to complete a Wyoming Medicaid Provider Enrollment Form and sign a Provider Agreement with Wyoming Medicaid.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 01: Provider's Role

201 PROVIDER'S ROLE

1. General

a. Each Medicaid provider shall be certified under state law to perform the specific services.

b. Certify that each covered service provided is therapeutically essential and that the prescribed are in accordance with accepted norms of mental health and substance abuse practice.

c. Providers are required to maintain records of the nature and scope of the care furnished to Wyoming Medicaid recipients. Documentation requirements are specified in Section 305 and 306.

2. Treatment Necessity for the Reduction of Mental Health/Substance Abuse Disability

The Wyoming Medicaid program is designed to assist eligible recipients in obtaining medical care within the guidelines specified by Wyoming policy. Medicaid will pay only for medical services which are therapeutically essential and are sponsored under program directives. The services shall be:

1. Consistent with the diagnosis and treatment of the patient's condition.

2. In accordance accepted norms of mental health/substance abuse therapeutic services.

3. Only those services required to meet the mental health/substance abuse needs of the patient.

4. Performed in the most appropriate setting required by the patient's condition. The provider's records shall substantiate the need for service by the findings and information to support treatment necessity and detailing the care rendered.

5. All claims are subject to both prepayment and post-payment review for treatment necessity.

Should the review determine that services do not meet all the criteria listed above, payment will be denied or, if the claim has been paid, action will be taken to recoup payment for those services.

3. Provider's Right to Exercise Professional Judgment

A medical provider is expected to use professional judgment when rendering services, provided such services are rendered within the scope and intent of this document.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 01: Provider's Role

4. Responsibilities of Mental Health/Substance Abuse Providers Under Mental Health Services Option, Targeted Case Management Option and EPSDT Mental Health Services

a. Each client shall be referred by a licensed practitioner who attests to treatment necessity as indicated by the practitioner's signature and date on the clinical assessment and the initial a subsequent treatment plans which prescribe rehabilitative, targeted case management or ESPDT mental health services. Treatment plans are required at an interval of every three (3) months or more frequently if needed.

b. Licensed practitioners who are eligible to refer and to sign for treatment necessity are persons who have current license from the State of Wyoming to practice as a:

Licensed Professional Counselor
Licensed Addictions Therapist
Licensed Psychologist
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Physician
Licensed Psychiatric Nurse (Masters)
Licensed Advanced Practitioner of Nursing (Special area of psychiatric/mental health)

c. For a licensed practitioner to be authorized to refer and to sign for treatment necessity, the agreement between the licensed practitioner and the provider by which the practitioner's responsibilities under the Medicaid mental health Rehabilitative Option, Targeted Case Management Option EPSDT mental health services are specified.

d. Any licensed practitioner under contract with, or employed by, a provider shall be required to submit Medicaid claims through then provider and to indicate the provider as payee.

e. Prior to the provider's billing Medicaid for mental health Rehabilitative Option, Targeted Case management Option and EPSDT mental health services a licensed practitioner shall sign and date the client's clinical assessment and written treatment plan, including the following statement, "I certify that the services in this treatment plan are therapeutically essential for the reduction of mental health/substance abuse disability". Only an original signature is valid.

f. Licensed practitioners who sign for services that are not therapeutically essential are subject to formal sanctions through Wyoming Medicaid and/or referral to the relevant licensing board.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 02: Qualifications for Participating Providers and Staff

202 QUALIFICATIONS FOR PARTICIPATING PROVIDERS AND STAFF

To be eligible to provide Medicaid Mental Health Clinical Services staff shall be:

a. Employed or under contract with a Mental Health Division certified mental health and Medicaid provider, and

b. Licensed, provisionally licensed, or certified by the State of Wyoming, or

c. A registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of supervised experience and training to provide mental health services after the awarding of the R.N.

To be eligible to provide Medicaid Substance Abuse Services, staff shall be:

a. Employed or under contract with a Substance Abuse Division certified substance abuse and Medicaid provider, and

b. Licensed, provisionally licensed or certified by the State of Wyoming, or

c. A registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of supervised experience and training to provide mental health services after the awarding of the R.N.

To be eligible to provide Medicaid Individual Rehabilitative Services, staff shall:

a. Be employed or under contract with a Mental Health Division certified Medicaid provider.

b. Be eighteen years of age or older.

c. Complete a basic training program, including non-violent behavioral management, and

d. Be supervised and meet the qualifications of a mental health technician or mental health assistant as defined by the Standards for the Operation of Community Mental Health and Substance Abuse Programs.

e. Under the direct supervision of the primary therapist for that client.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 02: Qualifications for Participating Providers and Staff

To be eligible to provide Case Management Services, staff shall be:

a. Employed or under contract with a Mental Health Division and/or Substance Abuse Division certified mental health or substance abuse and Medicaid provider, and

b. A Mental health or substance abuse professional, a mental health or substance abuse counselor, a mental health or substance abuse assistant as defined by the Standards for the Operations of Community Mental Health and Substance Abuse Programs, or

c. A registered nurse (R.N.), licensed in the State of Wyoming, who has at least two years of clinical experience after the awarding of the R.N.

d. Knowledge of the community and ability to work with other agencies.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 03: Mental Health/Substance Abuse Services

203 MENTAL HEALTH AND SUBSTANCE ABUSE COVERED SERVICES FOR CHILDREN AND ADOLESCENTS, AND ADULTS

Covered Services: Outpatient mental health and outpatient abuse services, subject to certain specific exclusions, in Section 206, 207, and 298, are covered by Medicaid for enrolled persons of any age.

Rehabilitative Option Services

Outpatient mental health and substance abuse treatment services are provided to all Medicaid recipients based on therapeutic necessity. Covered services are mental health rehabilitative services recommended by a physician, psychologist, advanced practitioner of nursing, or other licensed practitioner of the healing arts, pursuant to 42 CFR 440.130(d). Medicaid reimbursement for these services will not duplicate payments made to other public agencies or private entities under other program authorities for this same purpose.

a. Clinical Assessment - Contact with the recipient (and collaterals as necessary) for the purposes of completing an evaluation of the recipient's mental health and/or substance abuse disorder(s) to determine treatment needs and establish a treatment plan. This service may include psychological testing if indicated. This service is 15 minutes per unit.

b. Agency or Office-based individual/family therapy services - Therapeutic contact, within the provider's office or agency, with the recipient and/or collaterals for the purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a recipient's mental health or substance abuse disorder as specified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

c. Group Therapy – Therapeutic contact with two or more unrelated recipients and/or collaterals as necessary for the purpose of implementing each recipient's treatment plan. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan. This service is 15 minutes per unit.

d. Psychosocial Rehabilitation-Therapeutic contact with two or more recipients (and collaterals as necessary) for the purpose of providing a preplanned, structured program of community living skills training which addresses functional impairments and/or behavioral symptoms related to a recipient's mental and/or substance abuse disorder(s) to slow deterioration, maintain or improve community integration, to ensure personal safety and wellbeing, and to reduce the risk of or duration of placement in a more restrictive setting including a psychiatric hospital or similar facility. Services provided to family members

must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

i. Adult Psychosocial Rehabilitation: Therapist contact with targeted populations for the purpose of providing a preplanned and structured group program of community living skills training which addresses functional impairments and/or behavioral symptoms of the client's mental disorder in order to slow deterioration, maintain or improve community integrations, to ensure personal well being, and to reduce the risk of or duration of placement in a more restrictive setting including a psychiatric hospital or similar facility. Skills addressed may include:

(a) Emotional skills, such as coping with stress, managing anxiety, dealing constructively with anger and other strong emotions, coping with depression, managing symptoms, dealing with frustration and disappointment and similar skills.
(b) Behavioral skills, such as managing overt expression of symptoms like delusions and hallucinations, appropriate social and interpersonal interactions, proper use of medications, extinguishing aggressive/assaultive behavior.
(c) Daily living and self-care, such as personal care and hygiene, money management, home care, daily structure, use of free time, shopping, food selection and preparation and similar skills.
(d) Cognitive skills, such as problem solving, concentration and attention, planning and setting, understanding illness and symptoms, decision making, reframing, and similar skills.
(e) Community integration skills, which focus on the maintenance or development of socially valued, age appropriate activities.
(f) And similar treatment to implement each enrolled client's treatment plan.

Day of treatment does not include:

- Academic education
- Recreational activities
- Meals and snacks
- Vocational services and training

e. Children's Psychosocial Rehabilitation: This service is designed to address the emotional and behavioral symptoms of youth diagnosed with childhood disorder, including ADHD, Oppositional Defiant Disorder, Depression, Disruptive Behavior Disorder and other related children's disorder. Within this program there are group and individual modalities and a primary focus on behaviors that enhance a youth's functioning in the home, school, and community. Youth will acquire skills such as conflict resolution, anger management, positive peer interaction and positive self-esteem.

Treatment interventions include group therapy, activity based therapy, psycho-educational instruction, behavior modification, skill development, and similar treatment to implement each enrolled client's treatment plan. The day treatment program may include a parent group designed to teach parents the intervention strategies used in the program. A low staff to client ratio makes management of difficult youth possible.

f. Community-based individual/family therapy services - Therapeutic contact, outside of the provider's office or agency, with the recipient and/or collaterals for the

purpose of developing and implementing the treatment plan for an individual or family. This service is targeted at reducing or eliminating specific symptoms or behaviors which are related to a recipient's mental health or substance abuse disorder as specified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

g. Individual Rehabilitative Services-Therapeutic contact with enrolled recipients (and collaterals as necessary) for the purpose of implementing that portion of the treatment plan targeted to restoring basic skills necessary to function independently in the home and the community in an age-appropriate manner and for the purpose of restoring those skills necessary to enable and maintain independent living in the community in an age appropriate manner, including learning skills in use of necessary community resources. Individual rehabilitative services assist with the restoration of a recipient to his or her optimal functional level. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

h. Intensive Individual Rehabilitative Services: The short-term use of two skill trainers with one client in order to provide effective management of particularly acute behaviors that are violent, aggressive or self harmful. Individual rehabilitative services assist with the restoration of a recipient to his or her optimal functional level. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

i. Certified Peer Specialist Services: Therapeutic contact with enrolled recipients (and collaterals as necessary) for the purpose of implementing the portion of the enrolled recipient's treatment plan that promotes the recipient to direct their own recovery and advocacy process or training to parents on how best to manage their child's mental health and/or substance abuse disorder to prevent out-of-home placement; to teach and support the restoration and exercise of skills needed for management of symptoms; and for the utilization of natural resources within the community. Services are person centered and provided from the perspective of an individual who has experience with the mental health and/or substance abuse system to assist the recipient and their family with meeting the goals of the recipient's treatment plan. This service is targeted at reducing or eliminating specific symptoms or behaviors related to a recipient's mental health and/or substance abuse disorder(s) as identified in the treatment plan. Services provided to family members must be for the direct benefit of the Medicaid recipient. This service is 15 minutes per unit.

j. Psychiatrist Services: Refer to the Psychiatrist Services Section in the Wyoming Medicaid HCFA 1500 Provider manual for description.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 04: Mental Health/Substance Abuse Services

204 TARGETED CASE MANAGEMENT

Targeted Case Management for seriously mentally ill adults age twenty-one (21) and over is an individual, **non-clinical** service which will be used to assist individuals under the plan in gaining access to needed medical, social, educational, and other services. See Section 302 (7) for definition of persons eligible for this service (page 3-6).

The purpose of targeted case management is to foster a client's rehabilitation from a diagnosed mental disorder or substance abuse disorder by organizing needed services and supports into an integrated system of care until the client is able to assume this responsibility.

Targeted case management activities include the following:

a. Linkage: Working with clients and/or service providers to secure access to needed services. Activities include communication with agencies to arrange for appointments or services following the initial referral process, and preparing clients for these appointments. Contact with hospitalized clients, hospital/institution staff, and/or collaterals in order to facilitate the client's reintegration in to the community.

b. Monitoring/Follow-Up: Contacting the client or others to ensure that a client is following a prescribed service plan and monitoring the progress and impact of that plan.

c. Referral:

Arranging initial appointments for clients with service providers or informing clients of services available, addresses and telephone numbers of agencies providing services.

d. Advocacy: Advocacy on behalf of a specific client for the purpose of accessing needed services. Activities may include making and receiving telephone calls, and the completion of forms, applications and reports which assist the client in accessing needed services.

e. Crisis Intervention: Crisis intervention and stabilization are provided in situation requiring immediate attention/resolution for a specific client. The case manager may provide the initial intervention in a crisis situation and would assist the client in gaining access to other needed crisis services.

The client's primary therapist (employed or contracted by the community mental health or substance abuse center) will perform an assessment and determine the case management services required.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 05: Mental Health/Substance Abuse Services

205 MENTAL HEALTH AND SUBSTANCE ABUSE COVERED SERVICES FOR ENROLLED PERSONS UNDER AGE 21

EPSDT Mental Health Services

a. On-Going Case Management: On-going Case Management for persons under age twenty-one (21) is an individual, non-clinical service which will be used to assist individuals under the plan in gaining access to needed medical, social, educational, and other services.

The purpose of on-going case management is to foster a client's rehabilitation from a diagnosed mental disorder or substance abuse disorder by organizing needed services and supports into an integrated system of care until the client or family is able to assume this responsibility.

On-going case management activities include the following:

i. Linkage: Working with clients and/or service providers to secure access to needed services. Activities include communication with agencies to arrange for appointments or services following the initial referral process, and preparing clients for these appointments. Contact with hospitalized clients, hospital/institution staff, and/or collaterals in order to facilitate the client's reintegration into the community.

ii. Monitoring/Follow-up: Contacting the client or others to ensure that a client is following a prescribed service plan and monitoring the progress and impact of that plan.

iii. Referral: Arranging appointments for clients with service providers or informing clients of services available, addresses and telephone numbers of agencies' providing services.

iv. Advocacy: Advocacy on behalf of a specific client for the purpose of accessing needed services. Activities may include making and receiving telephone calls, and the completion of forms, applications and reports which assist the client in accessing needed services.

v. Crisis Intervention: Crisis Intervention and stabilization are provided in situations requiring immediate attention/resolution for a specific client. The case manager may provide the initial intervention in a crisis situation and would assist the client in gaining access to other needed crisis services.

The client's primary therapist will perform an assessment and authorize the case management services required.

b. Transitional Case Management: Contact with the child or adolescent (and/or collaterals as necessary) in order to complete all arrangements necessary for the child or adolescent to move to the family or surrogate family home in the community. The service may involve direct or telephone contacts to negotiate, plan, and coordinate services necessary to transition the child or adolescent to community placement. This service is billed as a one-time charge at the time of case opening by the provider agency.

Reimbursement will not include institutional discharge functions that are Medicaid reimbursable, nor will Transitional Case Management duplicate case management functions performed and reimbursed under the Wyoming Peer Review Organization contract.

This service is no longer a covered service beginning April 1, 2008. Instead, please use "ongoing case management" when applicable.

c. Intensive Child Treatment Services: Family-based intensive treatment as an alternative to residential, hospital, or institutional care (beyond stabilization of behavior or control of acute symptoms) that would otherwise be necessary for a severely emotionally disturbed child or adolescent. Services include twenty-four hour a day placement with trained therapeutic foster parents and recruitment of, training of and respite care for, therapeutic foster parents.

This service is no longer a covered service beginning July 1, 2008.

i. Eligibility Requirements

Reimbursable Intensive Child Treatment Services are available to children who are not able to be maintained (or could not be maintained) in his/her own home. The following criteria serve as a guide in determining the child's eligibility for this service:

A. Severe maladaptive or disruptive behavior as expressed in aggressive behavior toward animals or destruction of property. Other aggressive or self-destructive behaviors may include oppositional behavior, incorrigibility, running away behaviors, suicidal gestures, or having suicidal ideation.

1. Severe psychiatric symptoms that affect the ability to perform activities of daily living. The child may be extremely impulsive and demonstrate limited ability to delay gratification. Social and emotional immaturities impair their decision-making and place them at risk in the community. They may evidence psychiatric dysfunctions (hallucinations or delusions or bizarre behaviors) that require the constant attention of a caretaker.

2. Severe emotional problems associated with medical conditions. Close monitoring and therapy are required due to the child/adolescent not adapting to recommended medical treatment.

3. Severe emotional problems associated with sexual and/or physical which lead the child to avoid adult relationships and be detached from others. The child may be preoccupied with sexual content, act out as a perpetrator and/or victim.

4. Severe emotional problems associated with substance abuse. Excessive use of drugs and/or alcohol creating the need for a structured environment, close monitoring, frequent counseling, medical visits, and a well coordinated network of support.

5. Representatives form community agencies involved in the care of the child/adolescent will participate in the decision making process that results in a recommendation for Intensive Child Treatment Services, once it has been established by a licensed practitioner that the child/adolescent meets the eligibility requirements for the service.

ii. Reimbursement

Intensive Child Treatment Services will be reimbursed to the provider agency as one, all-inclusive rate for the services described above in the definition.

The provider agency shall bill two separate agencies for each day of service

1. Room and board costs of the placement are reimbursed directly to the provider by the local Department of Family Services which should be billed monthly by the provider for room and board at the rate established by the Department of Family Services.

2. The Intensive Child Treatment Services code covers remaining costs of services and is used on the Medicaid claim form to bill at the rate established by Wyoming Medicaid which pays the state match for the service.

iii. Age Limit

While EPSDT services are available to eligible persons under age 21, Intensive Child Treatment Services beyond age 18 will require prior approval from Wyoming Medicaid for shorter extensions of an existing placement based on reasons such as completion of high school or completion of a transition plan that is in progress before the person reaches age 18.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 06: Limitations-Mental Health/Substance Abuse Services

206 LMITATIONS-MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

1. Program Limitations

a. Medicaid Mental health Rehabilitative Targeted Case Management Option and EPSDT mental health services are limited to those eligible persons who have a primary diagnosis of a mental/substance abuse disorder on Axis I and/or Axis II in the most current edition of the Diagnostic and Statistical Manual Disorders (DSM).

b. Specifically excluded from eligibility for Rehabilitative Option, Targeted Case Management Option and EPSDT mental health services are the following diagnosis resulting from clinical assessment:

Sole DSM diagnosis on Axis III
Sole DSM diagnosis of mental retardation (317.XX, 318.XX, and 319.XX)
Sole DSM Axis I diagnosis of any V code and services provided for a V code diagnosis
Sole DSM diagnosis of 799.90 on Axis I or II
Sole DSM diagnosis of specific learning disorders (315.XX)

2. Extensions of Services

a. If the client continues in treatment and receives any Medicaid mental health or substance abuse service, a licensed practitioner as defined in Section 201 of this manual, shall sign and date a newly revised client treatment plan, including the treatment necessity statement, prior to billing Medicaid. Treatment plans are required at every three (3) months interval or more frequently if needed.

b. The provider shall establish a system of utilization review for treatment necessity in accordance with Section 302 of this manual.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 07: Provision of Mental Health and Substance Abuse Services to Residents of Nursing Facilities

207 PROVISIONS OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES TO RESIDENTS OF NURSING FACILITIES

Eligibility for Medicaid mental health and substance abuse services provided to enroll clients in the nursing facility is limited to the following services under the Rehabilitative Services Option:

a. Clinical Assessment

b. Community-Based Individual/Family Therapy

c. Group Therapy

d. Psychiatric Services (refer to the Psychiatric Services section of the Wyoming Medicaid-HCFA 1500 Manual)

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 08: Non-Covered Services

208 NON-COVERED SERVICES

a. Hospital liaison services that include institutional discharge functions that are Medicaid reimbursable to the institution.

b. Consultation to other persons and agencies about non-clients, public education, public relations activities, speaking engagements and education.

c. Clinical services not provided through face-to-face contact with the client, other than collateral contacts necessary to develop/implement the prescribed plan of treatment.

d. Residential room, board, and care.

e. Substance abuse and mental health prevention services.

f. Recreation and socialization services.

g. Vocational services and training.

h. Appointments not kept.

i. Day care.

j. Psychological testing done for the sole purpose of educational diagnosis or school placement.

k. Remedial or other formal education.

l. Travel time.

m. Record keeping time.

n. Time spent writing test reports with the exception of three hours allowed for report writing by a licensed psychologist for the purpose of compiling a formal report of test findings and time spent completing reports, forms and correspondence covered under case management services.

o. Time spent in consultation with other persons or organizations on behalf of a client unless:

i. The consultation is a face-to-face contact with a collateral in order to implement the treatment plan of a client receiving Rehabilitative Option services.

OR

ii. The consultation is a face-to-face or telephone contact in order to implement the treatment plan of a client receiving EPSDT Mental Health Services.

OR

iii. The consultation is a face-to-face or telephone contact in order to implement the treatment plan of a client receiving Targeted Case Management Services.

p. Groups such as AA, NA, and other self-help groups, and

q. DUI classes.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 09: Reimbursement

209 REIMBURSEMENT

1. Biannually, based on the Mental Health Division and Substance Abuse Division fee scale guidelines, Medicaid providers shall establish a client fee scale which complies with standards and which ensures that the highest fee charged to the provider's clients equals or exceeds the reimbursement rates applicable to Medicaid services.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 2: Covered Services and Limitations
Section 10: Causes of Payback

210 REASONS FOR PAYBACK

1. Payback of Medicaid reimbursement shall be required if services are not appropriately authorized or if services cannot be adequately verified. Payback of Medicaid reimbursement may be caused by:

    a. Lack of licensed practitioner signature and date on a clinical assessment and on treatment plans.

    b. Lack of a mental health/substance abuse therapeutic record note that corresponds to each billed service for each date shown on the billing (except weekly notes for day treatment, monthly note for intensive child treatment services and a daily note for case management services).

    c. A mental health/substance abuse therapeutic record note that documents a diagnosis or a service not covered by Medicaid but billed to Medicaid.

    d. A mental health/substance abuse therapeutic record note that shows length of time less than has been billed.

    e. A mental health/substance abuse therapeutic record note that does not show length of service.

    f. A billed service provided by a staff member who is not qualified to bill Medicaid for the service provided.

    g. Billed services for which known third-party coverage was not sought first.

    h. Insufficient documentation to:

        i. Substantiate the diagnosis

        ii. Demonstrate treatment that implements the treatment plan

        iii. Justify treatment necessity

    i. Billed services that are solely recreational, social, vocational, or maintenance, that do not correlate with the treatment plan.

    j. Duplicate billing.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 01: Quality Assurance

301 QUALITY ASSURANCE

Each provider of mental health and/or substance abuse services shall adopt and implement a written quality assurance program.

1. Quality Assurance Program Criteria

The quality assurance program of a provider shall, at minimum, meet these criteria:

a. Utilization and quality review criteria (Section 302).

b. Agency standards for completeness review and criteria for clinical records (Sections 303 and 306).

c. Definition of critical incidents which require professional review and review procedures (Section 304).

2. Quality Assurance Committee

The provider shall establish a Quality Assurance Committee to perform at least two reviews: utilization review/quality (peer) review and critical incident review (unless another body is designated for critical incident review). The reviews are discussed in Section 302 through 304. The Committee shall:

a. Review, at a minimum, a sample of 10 percent of all open Medicaid cases at least annually. The cases selected shall represent at least one open Medicaid case of every clinical staff member and shall represent a proportionate share of Medicaid mental health cases and substance abuse cases if the agency is certified to provide both programs.

b. Document the results of all client record reviews, including the signature of the reviewer and the date of the review. The results will be kept in a file separate from the clinical record.

c. Note in each clinical record reviewed the types of review that have been completed, the date of review, and the name of the reviewer.

d. Ensure that no clinician reviews a client in which that individual is the primary or co-therapist.

e. Keep a written record of all committee activities which include, at a minimum:

   i. The date of the activity.

   ii. Committee members, present and absent.

   iii. For each type of review, the client numbers of the charts reviewed, a summary of overall findings for that type if review, and recommendations for corrective action by the provider for each type of review.

   iv. The signature of the chairperson.

f. Write a formal report that synthesizes findings for each type of review at 12-month intervals and make recommendations to management staff for the improvement of services and corrections of deficiencies with documentation of necessary follow-up.

g. Submit to the appropriate Division, Mental Health and/or Substance Abuse Division, a copy of this annual quality assurance report.

h. Make available to staff and to the governing body, an annual summary report of the results. This summary shall be written to maintain client confidentiality.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 02: Utilization Review Purposes and Criteria

302 UTILIZATION/QYALITY (PEER) REVIEW PURPOSES AND CRITERIA

1. Purpose

Each provider shall implement a system of utilization/quality review. The purpose of utilization/quality review is to monitor appropriateness of service usage patterns in order to ensure that each client is receiving:

a. The type(s) and frequency of service appropriate to resolve the presenting problem(s).

b. No more and no less of the length of service(s) necessary to resolve the presenting problem(s).

Utilization review also serves as peer assessment of the clinical assessment, treatment plans, and client's progress. For each Medicaid service provided the system shall include a review of treatment necessity.

2. Utilization/Quality Review Criteria by Service

The following are the documentation requirements for utilization/quality review by service.

a. Clinical Assessment

i. Screening to determine that there is reason to believe that the person has a DSM (latest edition) Axis I or Axis II diagnosis.

ii. Treatment necessity is certified by the signature and date of the licensed practitioner.

b. Agency-Based and Community-Based Individual/Family, Group, Day Treatment

i. Established of DSM (most current edition) diagnosis other than a diagnosis of mental retardation, specific developmental delay, deferred diagnosis, or V Code diagnosis.

ii. A treatment plan with at least one behaviorally measurable goal that addressed targeted change in symptoms/behaviors of mental disorder.

iii. Document that treatment is of benefit to the client.

iv. Treatment necessity is certified by the signature and date of a licensed practitioner on every initial and three (3) month treatment plan.

c. Individual Rehabilitative Services

i. Documentation, that the client's diagnosed mental health/substance abuse disorder has impaired the enrolled client's basic living and/or social skills.

ii. Documentation, in the treatment plan, of the changes that the enrolled client will exhibit in basic living and/or social skills.

iii. Treatment necessity is certified by the signature and date of a licensed practitioner on every initial and three (3) month treatment plan.

d. On-Going Case Management

i. Evidence that the client requires an array of provider and community agency services which need to be accessed and coordinated into an integrated system of care.

ii. A treatment plan, developed by the primary therapist which includes case management services.

iii. Treatment necessity is certified by the signature and date of a licensed practitioner on every initial three (3) month treatment plan.

e. Transitional Case Management

i. Documentation that the child or adolescent has a serious emotional disorder which resulted in hospital, residential or institutional placement.

ii. A plan of services, signed by a staff member qualified to be a primary therapist and describing the types of case management activities necessary to transition the client from residential, hospital, or institutional placement in the community with client's own family or a surrogate family.

iii. Documentation that the client was enrolled by the provider as an agency client and received a clinical assessment.

iv. Treatment necessity is certified by the signature and date of a licensed practitioner on every initial and three (3) month treatment plan.

f. Intensive Child Treatment Services

i. Documentation that the child or adolescent has a serious emotional disorder to the extent that the residential, hospital, or institutional care would be necessary in the absence of this service.

ii. A treatment plan with at least one behaviorally measurable goal.

iii. Treatment necessity is certified by the signature and date of a licensed practitioner on every initial and three (3) month treatment plan.

g. Targeted Case Management Service

i. Documentation that the client eligibility requirements for this service:

Targeted Group: Persons with a serious mental illness who are defined as persons age twenty one (21) and older who have a mental disorder that results in a long-term limitation of the person's capacity to function in activities of daily living and to remain in his/her home community without a range of treatment and other services.

1. Targeted case management services are provided to Medicaid eligibles who have been diagnosed by a mental health professional with one of the following mental illnesses:

A. Schizophrenia and Other Psychotic Disorders (295.xx, 297.xx, 298.xx)

B. Major Depressive Disorders and Bipolar Disorder (296.xx; severe, recurrent, not in full remission)

C. Anxiety disorder, personality disorder or a combination of mental disorders sufficiently disabling to meet criteria of functional disability.

2. Targeted case management services are provided to Medicaid eligibles who have been diagnosed by a substance abuse professional with a substance dependence disorder (303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90)

AND

3. Exhibit impaired role functioning, resulting solely from the mental disorder or a substance abuse disorder, in at least one of the following areas, continuously or episodically for at least one year:

   A. Inability to be self-supporting financially which includes unemployment, marked limited job skills, poor work history, receiving public assistance or disability payments based on mental illness, employed in a supported setting.

   B. Inability to function independently in daily living activities which includes personal care, household management, financial management, use of community resources including treatment for physical and mental health problems.

   C. Inability to exhibit appropriate social behavior which includes exhibiting inappropriate or dangerous social behavior which brings the person to the attention of mental health and/or law enforcement systems.

4. The following mental disorders are not included in the definition of mental illness:

   A. A sole diagnosis of mental retardation or other developmental disability. (Services are provided through the Division of Developmental Disabilities.)

   B. A sole diagnosis of a substance abuse disorder. (Services are provided through a substance abuse treatment program.)

   C. Mental disorders, due to a medical condition, for which supervision primary intervention needs. (Services are usually provided in nursing facilities or similar custodial settings.)

ii. Evidence that the client requires community services which need to be used and coordinated into an integrated system of care.

iii. A treatment plan signed and dated by the primary therapist which includes the specific plan for case management services.

iv. Treatment necessity, certified by the signature and date of a licensed practitioner on every initial and three (3) month treatment plan.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 03: Completeness Review

303 COMPLETENESS REVIEW

The provider shall have a system for ensuring that clinical records meet the requirements of Section 306 of this manual. Failure to provide sufficient documentation, per this manual, shall be considered a reason for pay-back.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 04: Critical Incident Review

304 CRITICAL INCIDENT REVIEW

1. Purpose

The purpose of critical incident review is the professional review of incidents which involve, at a minimum, actual injury to clients or actual injury to staff or others by clients.

2. Criteria

Each provider shall establish a list of critical incidents which require professional review. Such incidents shall include, but are not limited to, the following:

a. Client attempted or completed suicide.

b. Client attempted or completed homicide or serious injury.

c. Any client death.

All critical incidents shall be review. The provider may convene the agency's Quality Assurance Committee or another group of professionals to perform the critical incident review.

3. Documentation

Documentation of reviewed critical incidents shall include at minimum:

a. Facts of the situation

b. Action taken to resolve the situation, if applicable.

c. If applicable, preventive changes needing to be made by the provider in agency policies or procedures and documentation of the change(s) implemented.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 05: Documentation and Records

305 CUMENTATION AND RECORDS

1. Requirement

The provider Agreement requires that the clinical records fully disclose the extent of treatment services provided to Medicaid recipients. The following elements are a clarification Medicaid policy regarding documentation for medical records:

a. The record shall be typed or legible written.

b. The record shall identify the patient on each page.

c. Entries shall be signed and dated by the qualified staff member providing service.

d. The record shall contain a preliminary working diagnosis and the elements of a history and mental status examination upon which the diagnosis is based.

e. All services, as well as the treatment plan, shall be entered in the record. Any drugs prescribed by medical personnel affiliated with the provider, as part of treatment, including the quantities and the dosage, shall be entered in the record.

f. The record shall indicate the observed mental health/substance abuse therapeutic condition of the recipient, any change in diagnosis or treatment, and the recipient's response to treatment. Progress notes shall be written for every contact billed to Medicaid.

g. The record must include a valid consent for treatment signed by the client or guardian.

Pursuant to Wyoming Medicaid Rules, Chapter 3-Provider Participation, "Documentation requirements" a provider must have completed all required documentation, including required signatures, before or at the time the provider submits a claim to the Division. Documentation prepared or completed after then submission of a claim will be deemed to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

2. Retention of Records

Providers shall maintain clinical and financial records, including information regarding dates of service, diagnosis, services provided, and bills for services, for at least six years after the end of the state fiscal year in which payment for services was rendered. If an audit is in progress, the records shall be maintained until the audit is resolved.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 05: Documentation and Records

3. Access to Records

a. Under the provider Agreement, providers shall allow access to all records concerning services and payment to authorized personnel of the State Auditor's Office. The Wyoming Attorney General' Office, the Wyoming Department of Health, the United States Department of Health and Human Services, and/or their designees. Records shall be accessible to authorized personnel during normal business hours and for the purpose of reviewing, copying, and reproducing documents. The United States Department of Health and Human Services shall have access to these records regardless of a provider's continued participation in the program.

b. In addition, upon request from Wyoming Medicaid, providers are required to furnish copies of claims and any other documentation.

c. Copies of clinical records requested by Wyoming Medicaid shall reimburse as follows:

A. A Five dollar access fee per patient record requested, plus

B. Ten cents per page for up to fifty pages.

C. Total reimbursement shall not exceed ten dollars per patient record.

D. A provider which seeks reimbursement for copy expenses shall submit an invoice to the Division with the requested records.

4. **Record Keeping Requirements:** Client Records

a. Providers of mental health/substance abuse services under the Medicaid mental health Rehabilitative Option, Targeted Case management Option and EPSDT mental health services shall maintain clinical and financial records in a manner that allows verification of service provision and accuracy in billing for services. Billed services not substantiated by clinical documentation shall be retroactively denied payment. The provider shall be responsible for reimbursing any Medicaid payments that are denied retroactively.

Pursuant to Wyoming Medicaid Rules, Chapter 3-Provider Participation "Documentation requirements." A provider must have completed all required documentation, including required signatures, before or at the time the provider submits a claim to the Division. Documentation prepared or completed after the submission of a claim will be deemed to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

Late entries made to the client's record are allowable to supplement the clinical record. Late entries are not allowable for the purpose of satisfying record keeping requirements after billing Wyoming Medicaid.

b. Requirements

In addition to the general documentation requirements listed above, the following requirements shall be met:

i. There shall be a separate clinical note made in each client's clinical record for every treatment contact that is to be billed to Medicaid (other than a weekly note for Day Treatment Services and Intensive Child Treatment Services). More frequent documentation is acceptable and encouraged.

ii. Each note shall show length of service.

iii. The provider shall adhere to clinical records standards defined in Section 306.

iv. The provider shall maintain an individual ledger account for each Medicaid client who receives services. The ledger account shall indicate, at a minimum:

A. The date and type of each treatment contact.

B. The length of contact rounded to the nearest 15-minute unit, per billing instructions.

C. The appropriate Medicaid charge.

Date that other third-party payers were billed and the result of the billing.

Services noted on the individual ledger account and billed Medicaid shall be substantiated by the clinical record documentation.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 06: Clinical Records: Content Requirements

306 CLINICAL RECORDS: CONTENT REQUIREMENTS

Each Medicaid provider shall establish requirements for the content, organization, and maintenance of client records. The content of clinical records shall include, at a minimum:

a. Documentation of client consent to treatment at the agency. If an adult client is under guardianship, consent shall be obtained from the guardian. In the case of minors, consent shall be obtained from a parent or the guardian. Wyoming Medicaid shall not reimburse for services delivered before a valid consent is signed.

b. A client fee agreement, signed by the client or guardian. For Medicaid, this agreement shall include authorization to bill Medicaid, and other insurance if applicable, using the following statement, "I authorize the release of any treatment information necessary to process Medicaid/insurance claims."

c. A specific fee agreement for any Medicaid non-covered service, and the fee that an enrolled client agrees to pay.

d. Documentation that each client has been informed of his or her client rights.

e. A clinical assessment completed prior to the provision of treatment services which shall include at a minimum:

   i. The specific symptoms/behaviors of a mental/substance abuse disorder which constitute the presenting problem.

   ii. History of the mental/substance abuse disorder and previous treatment.

   iii. Family and social data relevant to the mental/substance abuse disorder.

   iv. Medical data, including a list of all medications being used, major physical illnesses, and substance use and abuse (if not the presenting problem).

   v. Mental status findings.

   vi. A diagnostic interpretation.

   vii. A DSM (most current edition) diagnosis.

   viii. Development of the initial treatment plan with the client.

f. A treatment plan completed prior to or within five (5) working days of the third face-to-face contact.

   i. The treatment plan shall state the specific therapeutic change(s) the client will exhibit in symptoms/behaviors of the mental/substance abuse disorder within the three (3) month covered by the treatment plan.

   ii. The treatment plan shall state the anticipated type and frequency of each reimbursable Medicaid service to be provided.

   iii. The treatment plan shall include the date and signature of a licensed practitioner

g. Except for day treatment, Substance Abuse Intensive Outpatient Services, Intensive Child Treatment Service, Individual Rehabilitative Services, and Case Management Services, a separate progress note in the clinical record for each face-to-face contact with the client and with others who are collaterals to implement the client's treatment plan. Progress notes shall include:

   i. The name of the Medical-reimbursable service rendered.

   ii. The date, length of time and location of the contact.

   iii. Persons involved (in lieu or in addition to the client).

   iv. Summary of client condition, issues addressed, and client progress in meeting treatment goals.

   v. Signature, date and degree of treating staff member.

h. For day treatment, a weekly progress note is required. The note shall document:

   i. The date and length of time of each day's contact.

   ii. A weekly summary describing therapeutic activities provided and client's progress in achieving the treatment goal(s) to be accomplished through day treatment. A daily progress note is acceptable in lieu of a weekly summary.

   iii. Signature, date and degree of treating staff member.

i. For Individual Rehabilitative Services, a separate chart note shall document each day's contacts to be billed, including:

   i. The date and length of time of each day's contact.

   ii. Activities of the skill trainer and activities of the client.

   iii. Any significant client behavior observed.

   iv. The date and signature of the skill trainer.

   v. The location of service.

   vi. The signature and date of the primary therapist.

j. For Transitional Case Management Services

   i. A plan of services written by a staff member qualified to be a primary therapist and describing the types of case management activities necessary to transition the client to placement in the community with the client's own family or a surrogate family.

   ii. A summary describing all case management activities provided, including:

      A. The dates and length of time of any case management activity.

      B. Type and description of each day's services.

      C. The date and signature of the case manager.

      D. The signature and date of the primary therapist.

k. For On-Going Case Management Services and Targeted Case Management Services, a separate chart note shall document each day's contacts to be billed, including:

   i. The date and length of time for each day's contacts.

   ii. Type and description of each day's services.

   iii. The date and signature of the case manager.

   iv. The signature and date of the primary therapist.

l. For Intensive Child Treatment Services, the clinical record shall contain:

   i. A monthly progress note which documents each day's enrollment in Intensive Child Treatment Services and a summary of the client's condition and progress in relation to meeting treatment goals, including any issues or problems relating to the treatment family and continued placement signed by the primary therapist. More frequent progress notes are acceptable in lieu of the monthly progress note.

   ii. A separate signed progress note for each clinical and case management service provided.

   iii. Date, signature and degree of the primary therapist.

m. A provider of Intensive Child Treatment Services shall maintain a separate, non-clinical record of required training for therapeutic foster parents. The record shall include:

   i. The date, length of time, and content description of each training provided to therapeutic foster parents.

   ii. A sign-in sheet for each therapeutic foster parent to sign when attending each training session. The sheet shall indicate whether the therapeutic foster parent is attending for purposes of pre-service training or on-going training.

n. A chronological record of medications prescribed and/or dispensed by a provider employee or contract employee on site.

o. Properly executed release of information, as applicable, and chart documentation of information received or released as a result of the written client consent.

p. Testing, correspondence, and like documents or copies.

q. For any client seen for ten or more therapeutic contacts, a discharge summary which includes each type of Medicaid service received, client progress in achieving treatment goals, and plans for follow-up, necessary. The discharge summary shall be completed within 90 days of the last contact. Any clinical record shall document the reason for case closure.

WYOMING MEDICAID PROGRAM
MANUAL TITLE: Community Mental Health Manual
CHAPTER 3: Utilization Review
Section 07: Medicaid Quality Control

307 MEDICAID QUALITY CONTROL

A Medicaid quality control system shall be implemented for the purpose of reducing erroneous expenditures, for implementing corrective action to correct errors and to reduce the incidence of errors, and for reviewing both utilization of services and quality of services.

The provider shall be responsible for reimbursing excess payments. Excess payments are funds received by a provider to which the provider is not entitled for any reason, including payments which exceed the Medicaid allowable payment. Per Wyoming Medicaid Rule, Chapter 39, "Excess payment" includes, but is not limited to:

i. Overpayments.

ii. Payments made as a result of system errors.

iii. Payments for services furnished to a non-recipient.

iv. Payments for non-covered services furnished to a recipient.

v. Payments for services which are not documented and/or supported by medical records and/or financial records.

vi. Payments which exceed a provider's usual and customary charge, unless otherwise permitted by the Department's rules

1. Random Claims Review

Wyoming Medicaid shall use its customary random case system for reviewing Medicaid mental health and substance abuse cases. The review process includes review of the following types of errors:

a. Claims Processing Error

i. Payment was made for a service not authorized by the State plan.

ii. Payment was made to a provider not certified for participation in the Medicaid program.

iii. Payment was made for a service already paid for by Medicaid.

iv. Payment was made in an amount above the allowable reimbursement level for that service.

b. Eligible Error

i. The client was not eligible for Medicaid at the time that the service was rendered.

ii. Payment was made for treatment services rendered under a diagnosis that does not qualify for reimbursement under the Medicaid mental health Rehabilitative Option, EPSDT or targeted case management option.

c. Third-Party Liability Error

i. Payment was made when all or part of the cost should have been paid for by a third party.

ii. Payment was made in the absence of documentation of response from a potential third-party payer.

2. On Site Review

Reviews of these error reviews shall be made available to Wyoming Medicaid which may elect to conduct an on site review of a provider's Medicaid program, including clinical and other records based on reports of these error reviews.